Iowa Department of Human Services

Transition Committee Report

January 10, 2013

Table of Contents

Introduction

The purpose of this report is to provide information and recommendations to the Iowa Legislature related to the implementation of Senate File 2315: the Mental Health and Disability System Redesign Legislation enacted in 2012. This report summarizes the deliberations and recommendations of the Transition Committee.

In consultation with the Legislative leadership, the Department of Human Services ("Department") formed the Transition Committee to focus on the transition from the existing mental health and disability system (MHDS) into the new regional system. This committee included several members from the Regionalization Workgroup that assisted to develop recommendations for the regional system design that was a basis for last year's Legislative action (SF 525). New participants were added to increase representation of the Mental Health and Disability Services (MHDS) Commission and county officials, both of which are important participants in the implementation process. A complete list of the membership of the Transition Committee is included as Appendix A of this report.

The goal of the committee is to transition to a regional mental health system that provides local access to services and supports, is regionally managed and measured through statewide standards. The specific tasks of the Transition Committee include:

- Identify and recommend resolutions for issues arising from the mental health and disability system transition;
- Serve as a resource for the Department as it assists counties forming into regional entities;
- Make recommendations that would create a clear locus of accountability and responsibility in the MHDS system; and

Consult with the Department and the MHDS Commission as they establish rules for county exemption from a region and rules and requirements for the Mental Health and Disability Services Redesign Transition Fund.

The Transition Committee met five times in person, and twice by conference call between July 31, 2012, and December 2012. The Committee anticipates continuing its work beyond the delivery of this report, to assist the Department and the Legislature as they consider and perhaps adopt the recommendations of this report, and to continue to advise and facilitate the implementation process through the up-coming year.

Status Report

The Transition Committee spent part of each meeting discussing two issues directly relevant to the success of the redesign implementation. These were: (a) financial issues at the county level that could influence the formation of regions and/or highlight issues related to the Redesign Transition Fund; and (b) status reports of the numbers and types of regions under consideration by counties.

Financial issues at the county level

Prior to counties submitting applications for transition funds, the Department was watching the counties' financial conditions. As of the end of October 2012, it appeared that 70 counties are in good financial condition and are likely to end the fiscal year with positive fund balances, while 29 counties appeared to have insufficient funds to meet all obligations and may end the year with negative fund balances. Some of these counties may have difficulty meeting their obligation to reimburse the state for Medicaid match costs incurred prior to the state assuming full financial responsibility for all Medicaid costs. It appears there is not a correlation between financial challenges within counties and eligibility to receive an allocation from the Redesign Transition Fund. That fund is specifically designed to assure continuity of services for consumers while counties are transitioning into the regional system, not to assist counties to meet prior financial obligations. This will be discussed in more detail in the recommendations below.

The Department has conducted an analysis of the drivers of financial issues among the 29 counties that appeared to have fiscal challenges. It appears there are a number of factors that have influenced county financial issues and that these are often interactive. While not always the case counties experiencing several of the factors seem to have more challenging financial issues. The drivers of financial problems at the county level include but are not limited to:

- A lower maximum allowable MHDS county levy;
- A history of higher per capita spending for Medicaid services;
- A history of higher per capita spending for non-Medicaid services;
- A history of higher spending per person served for non-Medicaid services;
- A history of higher use of psychiatric inpatient services; and/or
- A history of serving a higher number of persons per 1,000 persons in the general population.

The Department plans to continue to watch these financial situations on a county-by-county basis. In many cases, the solutions will not necessitate reduction in services nor will they necessarily require regional partners to share in the solution, although that could be an option. One option would be for the Legislature to appropriate state general funds to meet local obligations.

Progress in Regional Formation

The Department has been monitoring local discussions and potential partnerships among counties as they form themselves into regions. As of October 30, 2012, the Department understood there were 96 counties in the process of forming approximately 15 regions. Information on these potential regions is summarized in the table below:

Summary Information on Counties forming Regions

Number considering model	Number of counties considering this model
Single County Region w/ waiver	2
Two County Region with Waiver	2
Region with 3 Counties	1
Region with 4 counties	2
Region with 5 counties	6
Region with 6 Counties	1
Region with 7 Counties	3
Region with 9 Counties	1
Region with 18 Counties	1
Unknown	2

Results of the Transition Committee Work

The Transition Committee had several specific recurring agenda items intended to result in specific recommendations to the Department and the Iowa Legislature. These included specific recommendations related to rules for the Transition Fund and the granting of waivers for single county operations. It should be noted that in the case of the development of rules, the Transition Committee was an active and effective partner with the Department and the MHDS Commission. The recommendations of the Transition Committee also included some more generic topics regarding desired models and administrative practices for the operations of newly formed regions.

Recommendations related to these key topics are summarized below.

Recommendation: Rules for the Transition Fund

The statutory framework for the Transition Fund [1]specifies that the funds are to be for FY 2013 for one time assistance to sustain services for populations currently receiving non-Medicaid funded services as approved by the county's management plan. The statute required that county Boards of Supervisors be the applicants for the funds; that the county be levying the maximum allowable for that county; and that there be independent verification of the applicant county's financial position. To be eligible for funding, counties had to demonstrate that the amount, duration and scope of current county services cannot be maintained in the absence of transition funding.

The Mental Health and Disability Services Redesign Transition Fund rules were adopted and became effective on September 11, 2012. The rules specified that applications for Transition Funds were to be submitted to DHS by November 1, 2012. Applicant counties were instructed to use a specific[2] form for their submissions. The

[1] SF 2315 Section 23
[2] Form 470-2125

form replicates all the consumer targeting criteria, core services[3] and financial information specified in the rule, and were to be verified independently by the applicant county's auditor.

The Department received 32 applications for Transition Funds. The applications were reviewed, and the Department made its recommendation to the Legislature in its December 4, 2012 report.

Recommendation: Readiness Criteria for Operations as a Region

Once recommendations related to the rules and application processes for the Transition Fund were completed, The Transition Committee began discussions of criteria that could be used by the Department to evaluate whether one or two counties[4] could qualify for a waiver to function as a region. The Committee recognized that before criteria for a waiver could be discussed, it would be necessary to have a more general discussion of threshold criteria to be met by groups of counties seeking Department approval to operate as a region. One specific reason for this is that the statute specifies that counties seeking waivers must meet all standards and requirements applicable to multi-county regions.

The Transition Committee recognized that moving from single county to regional operations would be a developmental process, and that not all regions would be able to meet all criteria at the beginning of the process. However, the Committee also recognized that regions will have to meet certain basic criteria (a) to meet the requirements set out in SF 2315; and (b) to enter into a performance contract with the Department for the first year of operations. There was general consensus among Committee members that the following list represents objective threshold criteria for regional operations. It should be noted that single or two-county regions are required to meet the same threshold criteria for regional operations as larger regions.

1. Planning
    a. The region has a complete management plan/business plan and is developing an operations manual that meets all new statutory requirements that includes provision of core services as defined by SF 2315, eventual provision of core plus services.
    b. The management plan demonstrates effective linkages with other public and private service planning, authorizing or delivery entities to assure continuity of care and coordination of services with regard to physical health, housing, employment, education, courts, criminal justice and other applicable community services and supports.
    c. The plan documents the input of consumers, families, providers, and other stakeholders in the plan development process.

[3] Current services as per the county management plan

[4] Because the statute specifies a minimum of three counties per region, a two-county region would still have to receive a waiver for DHS to operate as a region.

2. Access
    a. There are a sufficient number and adequate geographic distribution of designated access points to assure convenient access throughout the region.
    b. Protocols for timely responses to routine, urgent and emergent requests for services are in place.
    c. There is a plan to communicate access points and related information to all actual and potential consumers, families, referral sources and other key community stakeholders.
    d. There is a 24/7/365 telephone contact system in place.
    e. The management plan addresses access issues: in rural areas, for cultural/linguistic minorities, for people with physical and other disabilities, etc.

3. Provider network sufficiency
    a. The region has contracts or memoranda of understanding (MOU) with providers for each of the core service domains as defined by SF 2315 and any other services included in the management plan.
    b. Providers in the network that are also Medicaid certified providers agree (via contract or MOU language) to collaborate with the region to assure care coordination and continuity of care across Medicaid and non-Medicaid services.
    c. The provider network includes at least one community mental health center that can serve the entire region and/or one FQHC with outpatient mental health service capacity to serve the entire region.
    d. The provider network includes at least one inpatient mental health facility with documented capability and willingness to provide inpatient acute care as applicable to residents of the region.
    e. The provider network includes sufficient providers to offer reasonable choice and convenience of access to services throughout the region's service area.
    f. All providers in the network have the applicable licensure/certification/accreditation to qualify as providers in Iowa.
    g. Regional or contracted provider capacity is identified to address pre-admission screening and hospital and jail diversion functions and capacities.

4. Targeted Case Management (TCM)
    a. The region assures that consumers have choice of conflict free targeted case management providers with the capacity to meet the case management needs of enrolled consumers.
    b. The Region assures that designated TCM providers are certified by Medicaid.

5. Utilization management/utilization review
    a. The region has (or contracts with) sufficient skilled clinical capacity to conduct or review clinical assessments; review individual service plans; apply standard clinical protocols as defined in the management plan; and issue service authorizations/re-authorizations in a timely and clinical appropriate manner.
    b. The region has in place a process and capacity to address and make timely decisions on first level appeals of service denials.

6. Quality management
    a. The region has identified a staff person with lead responsibility for quality management and quality improvement (QMQI), and will develop a quality management plan with specific objectives, action steps and indicators of quality improvement within the first year of operations.
    b. The quality management plan will incorporate performance measures required by the Department.
    c. The region has a plan and designated staff to review outcome and performance data on a regular basis and to document the ways in which outcome and performance data are used for quality improvement.

7. Business management
    a. The region has a business and financial risk management plan to assure precise financial analysis and early warning of financial risks, and that identifies the percentage of budget to be set aside for an internal risk pool.
    b. The region has sufficient IT capacity to receive, adjudicate and pay provider claims and to meet all state data reporting requirements.
    c. The region has a staffing plan that identifies sufficient staff expertise and functional capacity to meet all requirements for operating as a region.
    d. The total administrative costs of the region do not exceed the administrative costs limitations established by the Department.

The Transition Committee recommends that the Department provide guidance to regions on the above types of operational criteria to facilitate their planning and development process. The Department will provide direct technical assistance to regions if appropriate to facilitate development of systems and capacities to assure effective implementation of the new regions.

Recommendation: Recommendations for Waivers for Single (or Dual) County Operations

The above general criteria for regional operations were then used by the Transition Committee to develop recommendations related to (a) qualifications to apply for a waiver; and (b) criteria for review of such applications if received. The statute is very clear that a single (or dual) county applicant for a waiver would have to meet virtually all the statutory requirements that apply to multi-county regions. The MHDS Commission also held several discussions of this issue and provided feedback and guidance to the

Transition Committee with regard to formulation of the rules and criteria for waiver applications and review.
The Transition Committee reached consensus that the following principles reflect the intent of the statute with regard to single (or dual) county waivers:

1. A single (or dual) county region must meet all the statutory, regulatory and performance requirements as a multi-county region.
2. A single (or dual) county region will have to submit a new county management plan/business plan (including manual) and have it approved in the same way as a multi-county region.
3. A single (or dual) county region will have to have a plan to meet performance criteria and standards in the same manner as a multi-county region.
4. It is recognized that steps to meet management plan and performance requirements for multi-county regions are developmental, and the same would be true for single county regions.

The Department has developed an outline of draft rules for single (or dual) county operations under a waiver granted by the Director of the Department. These were presented to the Transition Committee at the meeting on October 30, 2012. After discussion, and with additional input from the Committee members that are also members of the MHDS Commission, the Transition Committee reached consensus that the following outline is appropriate:

OUTLINE:
RULES FOR EXEMPTING COUNTIES FROM FORMING INTO REGIONS
October 30, 2012

Counties wishing to be exempted from forming into regions of counties of three or more must submit applications that meet the following requirements. A county/counties must demonstrate that the requirements are currently being met or provide a viable plan for meeting each requirement. The Director may deny a county/counties waiver application if:

- The county/counties cannot demonstrate it/they currently meet the requirements, and
- The county/counties do not have a viable plan for meeting the requirements, or
- At any point the county/counties do not meet any regional requirement consistent with 331.438B 5.

❖ Community engagement – Demonstrate that in the county or counties has/have:
  - Active operational understandings (e.g., memorandum of understandings) with other public and private service entities such as:
    - Physical health;
    - Housing;
    - Employment;
    - Education;
    - Courts; and
    - Criminal Justice.

- Obtained input from consumers, families, providers and other stakeholders regarding adequate community engagement.

- Access to core services – Demonstrate that in the county or counties there is/are:
  - A sufficient number and adequate service access points.
  - Access points that have been communicated to potential consumers, families and referral sources.
  - Effective response for emergencies including a 24/7/365 telephone contact system.
  - Access to service providers that have demonstrated the capability of providing:
    - Treatment that objectively meets the fidelity of evidenced based practices including:
      - Strengths based case management and/or assertive community treatment;
      - Illness management and recovery;
      - Family psycho-education;
      - Supportive housing;
      - Integrated treatment for co-occurring disorders; and
      - Supported employment;
    - Services to persons with co-occurring conditions including two or more of the following – mental illness, intellectual disability, developmental disability, brain injury, or substance use disorder; and
    - Trauma informed care.
  - Sufficient amounts of services that demonstrate that the per capita number of individuals:
    - Each disability category served by the county or counties is at least equal to or exceeds the statewide average;
    - Use of in-patient psychiatric hospital services is less than or equal to the statewide average; and
    - Using intermediate care facilities for individuals with intellectual disabilities is less than or equal to the statewide average.

- Provider network sufficiency – Demonstrate that the county or counties has/have:
  - Contracts to provide each service in the required core service domains in sufficient amounts to ensure a network of properly licensed and accredited providers can provide needed services without an undue wait times due to insufficient provider capacity;
  - A contract with a community mental health center or federally qualified health clinic that provides psychiatric services that provides services in the county or counties; and
  - An inpatient psychiatric hospital program within 100 miles of the county or counties.

- Targeted case management – Demonstrate that in the county or counties there is/are:

- Sufficient trained case managers or care coordinators to serve individuals needing the service at the required case load levels;
- Targeted case management that is strengths based and conflict free; and
- A choice of case management providers.

❖ Utilization management and review process – Demonstrate that the county or counties has/have:
- Sufficient skilled clinical capacity to issue clinically appropriate service authorizations.

❖ Quality Management/Improvement Process – Demonstrate that the county or counties has/have:
- A quality management/improvement plan that is managed by qualified staff;
- Incorporates performance measures required by the department; and
- A plan to review outcomes and performance measures regularly and to use the review to improve services.

❖ Staffing – Demonstrate that the county or counties staffing meets the requirements of 331.438B 3:
- The regional administrator is under the control of the governing board; and
- The regional administrator(s) shall have a bachelor's degree in a human service related field or public or business administration or relevant management experience.

❖ Business Management – Demonstrate that the county or counties has/have:
- A risk management plan that:
  - Accurately forecasts expenditures and revenue;
  - Provides an early warning of financial risks; and
  - A provision for effectively managing risk;
- The capability to fund current and on-going service obligations;
- An average cost of service per individual equal to or less than the statewide average;
- Administrative costs, as a percentage of non-Medicaid service expenditures, that are less than or equal to the statewide average;
- Maintain funding in designated accounts;
- An accounting system that conforms with OMB – A 87; and
- A process for performing an annual independent audit.

❖ Forming into a region is unworkable – Demonstrate that the county or counties has/have:
- Contacted all contiguous counties and determined that forming into a region with those counties is unworkable; and
- Identified the reasons why forming into regions with contiguous counties is unworkable.

❖ Maintain an approved management plan that meets all requirements.

It will be noted that the above outline includes some specific objective and measurable indicators related to performance. These are included because SF 2315 specifically requires single (or dual) counties to meet the same performance and outcome levels as the average of the regions. The new outcome and performance standards and indicators for regions are still in development. Further, it will take at least 1 year to generate performance data for the regions once the new indicators are implemented. Thus it is necessary to use existing data from current county MHDS operations for the purposes of the initial review of applications for single (or dual) county operations. Renewal of such waivers in subsequent years can be tied to the new outcome and performance requirements as data become available.

The Department is preparing draft rules for consideration by the MHDS Commission, and is also in the process of developing a format for counties to use if applying for a waiver. By statute, counties wishing to apply for a waiver must submit a letter of intent by May 1, 2013. At this time it is not clear whether any counties will be requesting a waiver and submitting a letter of intent. Currently, there are only two counties that have indicated some interest in requesting a waiver.

Recommendation: Guidance to the Department and the Director on Regional Formation and Implementation Issues

In the process of discussing the process and criteria for waivers for single (or dual) county operations, the Transition Committee developed a number of guiding principles related to the decision-making process. These principles are informed by considerable input from the MHDS Commission, which has been discussing the same topics and is responsible for promulgating the rules related to both the Transition Fund and single county waivers. The following is a summary of these guiding principles:

1. ***Legislative Intent***: The Committee emphasized that it was the intent of the Legislature that counties join regions. The provision for granting waivers is not intended to encourage counties to remain as single county operations. Rather the intent of the waiver process is to provide a small amount of discretion on the part of the Department to address situations in which joining a region is not feasible, and single (or dual) county operations is deemed by the Director of the Department to be in the best interests of consumers.

2. ***Urban core***: The Department should encourage regions in the formation process to include at least one populous urban core with numerous service providers and a variety of necessary other non-mental health and intellectual disability resources (education, employment, socialization, faith community, etc.). A non-populous county without an urban core and sufficient range and choice of providers should be encouraged to join a region, and should be discouraged from applying for a waiver for single county operations.

3. ***Minimum population size***: The Department should encourage counties to join in regions that have sufficient population and active caseload sizes to facilitate risk management, and to minimize per capita administrative cost ratios. Single

counties with relative low populations and case load sizes should be discouraged from applying for a waiver to function as a single county region.

4. ***Effect on surrounding counties***: When reviewing applications for waivers to be single county regions, the Department should take into account the effects on surrounding counties of granting such a waiver. This is particularly the case if the surrounding counties would be deprived of an urban core and sufficient population and case load sizes if the waiver is granted.

5. ***Flexibility***: The discretion and flexibility of the Department and the Director with regard to approving waivers and/or approving multi-county regions should be emphasized, particularly during the first 2 to 3 years while regions are still in the development stages. The Director also needs to have authority and discretion to assign "orphan" counties to a region if necessary.

6. ***Administrative Review***: A process for appealing Department decisions on granting waivers or approving regions is not currently included in the statute. It might be appropriate in the upcoming Legislative session to amend SF 2315 to include such an appeals process.

Recommendation: Additional Recommendations for Regional Operations
The Transition Committee recognizes that the Department will be responsible for oversight and management of the new regions and thus will need authority to specify administrative functions and criteria as well as outcome and performance standards for the regions. The Department and the regions together will need some flexibility and discretion to (a) make best use of administrative capacities, systems and personnel from the counties as they form into regions; and (b) determine allowable administrative functions, staffing and costs for the regions. At the same time, the Department must assure consistent and efficient management of public resources for non-Medicaid services at the regional level.

The Committee members agree that guidance to the counties as they form regions should be as concrete as possible. The Committee therefore discussed and reached consensus on some model administrative practices, or examples, which could be used by the Department and the regions to facilitate implementation. These could also be used by counties forming regions to evaluate whether their initial plans for administrating a given region are efficient and feasible. The following is a brief outline of these recommendations.

Example of Job Description for Regional Director
General Principles
1. Appointed by Board established by 28E agreement.
2. Serves at pleasure of the Board.
3. Has performance evaluated (annually) by the Board.
4. Functions as the Board's designated single point of accountability for all regional operations and finances.

Job Functions

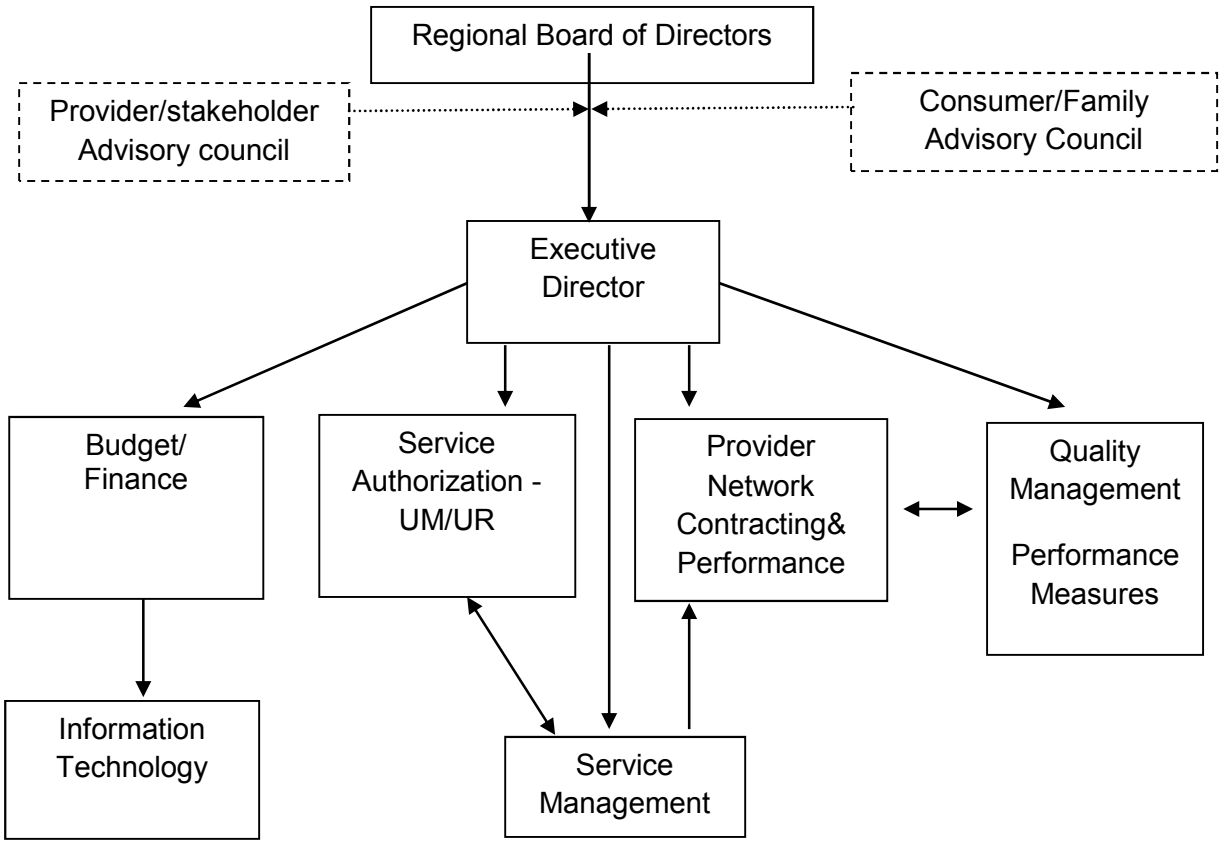
1. Functions as staff to the Board, oversees agendas and minutes, etc.
2. Develops and oversees communications with and input from relevant consumer, family and other stakeholder advisory groups.
3. Assures consumer and family input into needs assessments and strategic plan development.
4. Oversees development of the regional management plan (strategic and business plan) and operations manual.
5. Oversees development of the annual regional budget.
6. Oversees agency operations, including personnel, benefits, space, training, etc.
7. Implements a budget tracking and risk management plan to assure that annual expenditures remain within the annual budget.
8. Accountable for the region's compliance with all state requirements, including performance targets.
9. Develops regional administrative staffing plan and job descriptions.
10. Hires, supervises and evaluates the performance of regional administrative staff.
11. Designates regional access points.
12. Designates targeted case management providers, including conflict free case management where applicable.
13. Oversees the process for assessments, person centered planning, service plan development, service authorization, re-authorization and continuing review (utilization management and utilization review – UM/UR).
14. Oversees development and contracting for the provider network to assure all core services are available and accessible to the defined target populations.
15. Oversees monitoring of provider network quality and performance.
16. Assures timely and accurate payment of provider claims.
17. Oversees development and maintenance of effective working relationships and memoranda of agreement with all regional partners (housing, employment, education, social services, courts, police, hospitals, physical health providers [FQHCs], etc.).
18. Develops and oversees effective and transparent processes for coordinating service access and care planning for people receiving Medicaid services.
19. Assures that all financial, program, service, client and performance data are collected and reported in a timely and accurate basis.
20. Oversees development and implementation of the regional quality assurance plan.
21. Oversees regional appeals and grievances processes.
22. Develops monthly, quarterly and annual reports as specified by the Board and the Department.

Qualifications

1. Master's degree in management or human services/public policy (or bachelor's degree with 5 years management responsibility).
2. Minimum three years management responsibility (five years preferred) that includes accountability for organizational operations and budget (i.e., not just management of clinical or direct service staff).

3. Experience managing and overseeing business systems, including finance, accounting and information technology.
4. Knowledge of mental illness and intellectual disabilities.
5. Knowledge of human services systems, including Medicaid and non-Medicaid mental health and Intellectual disabilities financing and service delivery systems.
6. Experience developing and managing strategic and business plans.
7. Experience with using financial tracking and outcome and performance data for organizational management and quality improvement.

Example Functional Table of Organization for Regions (note: this is not a staffing plan and the boxes on the chart do not represent FTEs)



Business Plan Components

The Transition Committee understands that each region will be developing a regional strategic plan and operations manual as part of their initial and on-going operations. As part of the Regional Plan, the Transition Committee recommends that additional attention be paid to business planning. In this context, business planning includes accurate budgeting and tracking of expenditures, and also risk management to ensure that public funds are spent in the most efficient and effective manner. The challenge for regions will not just be to live within a fixed budget; it will also be to assure that the maximum amount of funds possible actually get spent on services for priority consumers. Under spending is frequently as much of an issue as overspending in a fixed budget, risk management environment.

Thus, the Transition Committee recommends that the business plan component of the regional strategic/business plan receive special attention. The following are some recommended elements for inclusion in the business plan:

1. Projected annual budget
    a. Administrative budget within the cost cap
    b. Provider payments

2. Analyses of revenue sources
    a. Projected annual revenues by source
    b. Projected monthly revenues by source

3. Monthly expenditure projections
    a. Provider payments
    b. Regional administration - payroll
    c. Historic analysis of average monthly client inflows and out flows and service authorization patterns

4. Monthly cash flow analysis (variance between projected monthly revenues and projected monthly expenditures)
    a. Historic analysis of receivables and effect on monthly cash flow
    b. Historic analysis of claims payment - adjustment factors by service/provider type

5. Method for accruing claims costs

6. Method for cleaning out un-paid claims

7. Method for tracking incurred but not received (IBNR) and received but unpaid claims (RBUC)

8. Assessment of financial risk factors – both to cash flow and to annual budget
    a. Revenue reduction/interruption

b. Unplanned expenditures
    i. Provider payments
    ii. Other (liability, etc.)
c. Provision for operating reserve
d. Provision for accessing fund balance
    i. Provision for accessing county fund balances for cash flow management and budget risk management if the fund balances are not pooled under the region

9. If applicable, identification of the fiscal intermediary for the region
    a. Specification of the functions and accountabilities of the fiscal intermediary

10. Specification of staff functions and accountabilities for financial tracking and risk analysis
    a. Description of the administrative firewall between budget/finance functions and service authorization and management functions

11. Specifications data and analytic approaches for linking intake, enrollment, service authorization, service utilization and client flow information with the budget tracking and risk management functions.

Administrative Cost Cap

SF 2315 requires the Department to collaborate with the Legislative Services Agency (LSA) to develop a standard administrative cost calculation and cap, or limit, for regions. The Department has been engaged in these meetings and is in the process of developing a recommended model. There is recognition that because counties (regions) will no longer have funds to pay the match for Medicaid, the denominator of total budget managed is smaller, thus the percentage of funds spent on administration will be greater. This is not necessarily an increase in administrative costs, but is related to the total amount of funds managed by the regions. The Department is currently defining which functions are truly administrative, and which functions are consumer services. This is a complex task, since some functions, such as care coordination and service management, have both administrative and service delivery components. Once the Department and LSA have developed a model for calculating administrative costs, it will be field tested in several counties (regions). The results of the field test will inform development of the final administrative cost definitions and limitations.

Transition Committee Recommendations for Legislative Action

On December 20, 2012, the Transition Committee identified several areas that they believe need further action by the Mental Health and Disability Services Redesign Fiscal Viability Study Committee. While some of the recommendations are broader in scope than the specific objectives of the Transition Committee, the Committee members believe making such recommendations would be consistent with the charge to: “Identify and recommend resolutions for issues arising from the mental health and disability system transition.”

The following recommendations are made by the Transition Committee and are not those of the Department.

Transition Funding
Although not within the mandate of the Transition Committee, the Committee did develop recommendations related to the Transition Fund. The Transition Committee believes that an alternative should be developed different from the one provided by the Department.

In general, it was the sense of the Committee members that there is greater need for funding to assure continuity of services than was reflected in the Department's recommendations. There was also concern about the emphasis on equity as a principle for funding. Committee members felt that Transition Funds were intended to assure no consumers lost services as a result of the transition, and therefore needed to reflect the current status quo of funding levels and priorities. It was noted that some counties that did not apply for Transition Funds had already reduced services to work within restricted budgets. Therefore, Committee members felt that the policy issue should be "fairness," not just "equity".

Committee members also made the point that counties/regions will need to have fund balances to be able to pay provider bills and sustain operations. If regions are expected to start operations without available fund balances, they will be financially insecure. The Committee does not believe this to be the intent of SF 2315 or the Transition Fund.

The Transition Committee recommends that a Transition Fund allocation method be developed and approved that uses the entire available CHIP contingency fund for the transition and unintended consequences related to redesign of Iowa's mental health delivery system passed by the 2012 Legislature.

Committee members observed that the MHDS Commission recommended adopting at least Scenario One described in the Department's Transition Fund Report.

Recommendation: No consumer, child or adult loses services as a result of the transition.
Several members of the Committee expressed their belief that the Legislature intended to preserve services for adults and children during the transition to a regional MHDS system. This position is similar to the discussion regarding the intent of the Transition Fund summarized above. Some Committee members have heard of counties cutting or restricting services because of limited funding, and/or to make sure they were not in a deficit situation, which could make them less attractive as partners in regions.

Recommendation: Establish $47.28 as the guidance for counties in determining their budget.
Committee members support enacting equalization funding at the $47.28 per capita level as proposed during the FY12 Legislative session. Some members indicated that certain counties had not applied for Transition Funds based on the belief that the $47.28

per capita funding would be sufficient to continue to provide services within the region. Committee members stated that it is important for counties/regions to begin budget planning for SFY14 as soon as possible and need to know if $47.28 will be the operative funding target. In the future, the per capita funding level should continue to be adjusted based on the documented service needs of priority consumers for core and core plus services in the future.

Recommendation: Allocation of equalization funds should be given to a region to be shared equitably among the counties in the region.
Committee members recommend that equalization funds up to the $47.28 level be awarded to regions as opposed to individual counties. Committee members believe this will reinforce the principle of pooling funds, and will allow regions to attain equalization of service access within their regions.

Recommendation: The Mental Health and Disability Services Redesign Fiscal Viability Study Committee establish an appeals process for counties requesting an exemption from joining a region if the Chapter 17A appeals process is deemed not effective.
The Transition Committee has noted that the Director of the Department has considerable discretion in (a) approving the make-up of regions; (b) assigning "orphan" counties to regions; and (c) granting or denying waivers for single or dual county operating as regions. Currently there is no specific language in SF 2315 that establishes an appeal mechanism related to these decisions. It is recognized that there is a generic appeals mechanism already in statute (Chapter 17A), but this might not be applicable to the above situations. Thus, the Transition Committee felt that the Mental Health and Disability Services Redesign Fiscal Viability Study Committee should review the appeal process issue and propose new statutory language if necessary.

Recommendation: Set aside the requirement for submitting a strategic plan for SFY14 as counties move to regionalization. The management plan will stay in place.
Several Committee members have noted that counties are operating under management plans that, although already extended for one year, will expire before all counties are effectively in regions with newly approved management plans. Committee members believe that the strategic action plan component could reflect the transition into regional structures. However, the current county management plan that details target populations, services, providers, access points, etc. should remain in effect until a county is officially joined into a region and a new regional management plan is approved.

Recommendation: The Mental Health and Disability Services Redesign Fiscal Viability Study Committee begin to look at systemic barriers to implementing co-occurring and multi-occurring service development and coordination strategies.
Committee members noted that some counties have coordinated local substance use disorders service funding (e.g., for detoxification services) with MHDS funding under the auspices of the central point of coordination administrator and county management

plan. This informal approach has assisted certain counties to facilitate integrated treatment for individuals with dual diagnoses of mental illness and substance use disorders, and has assisted counties to reduce administrative costs. SF 2315 requires the adoption of evidence based practices, and specifically endorses dual competencies for mental illness and substance use disorders among providers. However, there is currently no provision in SF 2315 that specifically allows counties to delegate certain substance use disorders funds management and service coordination functions to regions. The Transition Committee believes this issue requires further study and analysis in the next year.

Recommendation: Set June 30, 2013 as the end date for county obligations for Medicaid bills. After that date, the state would receive any credits and pay any obligations resulting from retroactive cost adjustments, etc. This would allow counties to move forward with budgeting.

Committee members and many constituent counties have experienced situations where Medicaid bills (and associated state bills to counties for match) can take long periods of time to be adjudicated, and frequently there are retroactive adjustments. Given the transfer of Medicaid responsibility and state funding from the counties to the state, counties need a clear break point beyond which they would no longer be liable for retroactive Medicaid match liabilities. Remaining property tax is insufficient to cover designated core services and pay old Medicaid bills. Enactment of this measure would facilitate budgeting and funds management within the new regional structures.

Recommendation: Money that is used for the current state payment program for services for individuals who are 100 percent county funded continue to be given to counties for SFY14.

State payment funds were available to counties to pay non-Medicaid services for individuals with no legal settlement. As counties transition to regions, the Committee requests these funds continue to be appropriated to the Department to allocate to counties (regions) to fund non-Medicaid services.

Recommendation: Individuals in the community corrections system have access to MHDS services and appropriate funding is allocated to pay for these services.

Committee members have noted that individuals under the control of the Department of Corrections (DOC) are residing in community settings as opposed to correctional facilities. While residing in the community, these individuals have a need for, and could benefit from, mental health and substance use disorder treatment services. Committee members agree that the regional MHDS system is most appropriate to access and assure provision of mental health services[5] for people in these community living settings; however, there is no funding mechanism to support service provision for these individuals. The Committee recommends that the Legislature designate the MHDS service system as the appropriate mechanism to deliver services and determine an appropriate service funding mechanism with adequate funds to pay for the services.

[5] Substance use disorder services are managed by Magellan, not the regional MHDS system.

Additional Requests by the Committee

There were two issues for which the Committee sought additional assistance for regions as they develop.

- Transition Committee members question how regions will obtain and pay for general liability insurance, particularly with regard to targeted case management. The Committee requests that the Department provide technical assistance to regions with regard to liability insurance as they develop their 28E agreements and begin organizational development and operations.

- The Transition Committee recognizes that the Department and LSA are working on a model for calculating regional administrative costs. A pilot for gathering administrative costs will be developed and field tested soon. The Committee would like assurance that regions will not be penalized in the administrative cost calculations because of the removal of the non-federal share of Medicaid from their budgets. The Committee recognizes that the denominator for administrative costs has changed, but it is not yet clear what the result will be in the new administrative cost model.

Conclusion

The Transition Committee believes that counties in Iowa are making strong and good faith efforts to form themselves into regions as specified by SF 2315. Over the course of the Transition Committee meetings, and in concert with the MHDS Commission, much progress has been made in setting specific and concrete rules for access to Redesign Transition Funds and applications for waivers to operate as a single or dual county region. Much clarity has also been achieved relative to effective administrative operations and practices for the newly forming regions. The committee is satisfied that SF 2315 is on track to effective implementation, and that only minimal adjustments might be needed either administratively or legislatively to facilitate on-going implementation.

The Transition Committee understands that the Legislature will receive and review this report, and will make a determination about any future actions to be taken either through appropriations or statute. At the same time, consideration will be given to whether a continued role for the Transition Committee would be appropriate over the upcoming year. One important function of the committee has been to discuss and provide guidance to the Department on implementation issues as they arise. The Transition Committee could also assist the Department if any unintended consequences related to regional formation and operations arise next year. The membership of the Transition Committee is broadly representative of many parties engaged in the implementation process, and thus is well poised to assist the Department with problem identification and solution formulation. The Department will communicate with the Legislature about possible continued operations of the Transition Committee after this report has been reviewed by the Legislature.

Appendix A
Transition Committee Members

Transition Committee Members

Name	Agency	Job Title
Chair, Palmer, Charles M	Department of Human Services	Director
Co-Chair, Lincoln, Bob	County Social Services Region	Central Point of Coordination
Bomhoff, Teresa	Polk County	Parent of Mental Health consumer
Brownell, Robert	Polk County Board of Supervisors	County Supervisor
Fokkena, Holly	Butler County	County Auditor
Guenthner, Jack	Plymouth County	County Supervisor
Heikes, Jan	Allamakee/Winneshiek Counties	Central Point of Coordination
Schmitz, Patrick	Plains Area Mental Health Center	Executive Director
Severtson, John	Opportunity Village	Chief Executive Officer
Tretina, Nancy		Parent of Intellectual Disability Consumer
Willey, Jack	Jackson County	County Supervisor
Rep. Lisa Heddens	Iowa House of Representatives	State Representative
Rep. Dave Heaton	Iowa House of Representatives	State Representative
Sen. Jack Hatch	Iowa Senate	State Senator